RULE-MAKING ORDER

CR-103 (June 2004)
(Implements RCW 34.05.360)

Agency: Department of Social and Health Services, Aging and Disability Services Administration

☒ **Permanent Rule**
☐ **Emergency Rule**

Effective date of rule:
Permanent Rules
☒ 31 days after filing.
☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Effective date of rule:
Emergency Rules
☐ Immediately upon filing.
☐ Later (specify) _____

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?
☐ Yes ☒ No If Yes, explain:

Purpose: Adopting new WAC 388-106-0745 through 388-106-0765 and amending WAC 388-515-1505 for the purpose of adding long-term care service and eligibility criteria for implementation of the long-term care portion of the Washington Medicaid Integration Partnership (WMIP). This is a new and innovative managed care program in the state of Washington that combines medical, mental health, chemical dependency, and long-term care services under one coordinated service delivery model and capitated payment structure, thereby improving client outcomes through increased coordination.

Citation of existing rules affected by this order:
Repealed: None
Amended: WAC 388-515-1505
Suspended: None

Statutory authority for adoption: RCW 74.08.090

Other authority : 42 CFR 441.302(a); Social Security Act section 1915(c) waiver rules; 42 CFR 438

PERMANENT RULE ONLY (Including Expedited Rule Making)
Adopted under notice filed as WSR 06-14-059 on June 30, 2006 .(date)
Describe any changes other than editing from proposed to adopted version:

"Added by DSHS after filing"

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:
Name: Tiffany Sevruk
Address: P.O. Box 45600
Olympia, WA 98504-5600
phone (360) 725-2538
fax (360) 407-7582
e-mail sevruta@dshs.wa.gov

ADOPTION
☑ PERMANENT
☐ EMERGENCY
EFFECTIVE DATE: 10/1/06

EMERGENCY RULE ONLY
Under RCW 34.05.350 the agency for good cause finds:
☐ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
☐ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

Date adopted: August 31, 2006

NAME (TYPE OR PRINT)
Robin Arnold-Williams

SIGNATURE
Robin Arnold-Williams

TITLE
Secretary, Department of Social and Health Services

CODE REVISER USE ONLY

CODE REVISER'S OFFICE
STATE OF WASHINGTON
FILED
AUG 31
TIME 2:28
WSR 06-18-058

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	___	Amended	___	Repealed	___
Federal rules or standards:	New	___	Amended	___	Repealed	___
Recently enacted state statutes:	New	5	Amended	1	Repealed	___

The number of sections adopted at the request of a nongovernmental entity:

New	___	Amended	___	Repealed	___

The number of sections adopted in the agency's own initiative:

New	___	Amended	___	Repealed	___

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	___	Amended	___	Repealed	___

The number of sections adopted using:

Negotiated rule making:	New	___	Amended	___	Repealed	___
Pilot rule making:	New	___	Amended	___	Repealed	___
Other alternative rule making:	New	5	Amended	1	Repealed	___

Washington Medicaid Integration Partnership (WMIP)

NEW SECTION

WAC 388-106-0745 What services may I receive under WMIP? (1) Once you are determined eligible, your care plan could include, but is not limited to, any of the following long-term care services:

(a) Care coordination;

(b) Personal care services in your own home or in a residential facility;

(c) Home health aide;

(d) Adult day services;

(e) Environmental modifications;

(f) Personal emergency response system (PERS);

(g) Skilled nursing;

(h) Specialized medical equipment and supplies;

(i) Home delivered meals;

(j) Residential care;

(k) Nursing facility care.

(2) The care plan may also include medical, chemical dependency, and/or mental health services.

NEW SECTION

WAC 388-106-0750 Am I eligible to enroll in WMIP? (1) To enroll in WMIP you must:

(a) Be aged, blind, or disabled;

(b) Be twenty-one years of age or older;

(c) Receive, or be eligible for, categorically needy medical assistance per WAC 388-500-0005; and

(d) Not be enrolled in any other comparable third party insurance coverage plan that purchases services on a prepaid basis (for example, a prepaid health plan).

(2) To be eligible to receive long-term care services under this program, you must meet functional eligibility for one of the long-term care programs per WAC 388-106-0210(2), WAC 388-106-0310(4), or WAC 388-106-0355(1) and financial eligibility for noninstitutional categorically needy, or institutional categorically needy as described in chapter 388-513 WAC and WAC 388-515-1505.

(3) Ongoing functional and financial eligibility for long-term care services will be determined at least annually by the state.

(4) If you are determined ineligible for long-term care services, you may continue to receive medical, mental health and chemical dependency treatment services through WMIP as long as you continue to meet the criteria listed in subsection (1) above.

NEW SECTION

WAC 388-106-0755 How do I pay for WMIP services? Depending on your income and resources, you may be required to pay for part of your long-term care services you receive through WMIP. The department will determine what amount, if any, you must contribute toward the cost of your care.

NEW SECTION

WAC 388-106-0760 How do I disenroll from WMIP? You may choose to disenroll from WMIP for any reason at any time. See WAC 388-538-061 for additional information on ending enrollment in WMIP.

NEW SECTION

WAC 388-106-0765 What is the fair hearing process for enrollee appeals of managed care organization actions? See WAC 388-538-112 for additional information specific to the managed care fair hearing process. For hearing information specific to long-term care services eligibility, see WAC 388-106-1305.

AMENDATORY SECTION (Amending WSR 06-03-079, filed 1/12/06, effective 2/12/06)

WAC 388-515-1505 Financial eligibility requirements for long-term care services under COPES, New Freedom, PACE, ((~~and~~)) MMIP, and WMIP. (1) This section describes the financial eligibility requirements and the rules used to determine a client's participation in the total cost of care for home or community-based long-term care (LTC) services provided under the following programs:

(a) Community options program entry system (COPES);

(b) Program of all-inclusive care for the elderly (PACE); ((~~and~~))

(c) Medicare/Medicaid integration project (MMIP);

(d) Washington Medicaid integration partnership (WMIP); and

(e) New Freedom Consumer Directed Services (New Freedom).

(2) To be eligible, a client must:

(a) Meet the program and age requirements for the specific program, as follows:

(i) COPES, per WAC 388-106-0310;

(ii) PACE, per WAC 388-106-0705; ((~~or~~))

(iii) MMIP waiver services, per WAC 388-106-0725;

(iv) WMIP waiver services, per WAC 388-106-0750; or

(v) New Freedom, per WAC 388-106-1410.

(b) Meet the aged, blind or disability criteria of the Supplemental Security Income (SSI) program as described in WAC 388-511-1105(1);

(c) Require the level of care provided in a nursing facility as described in WAC 388-106-0355;

(d) Be residing in a medical facility as defined in WAC 388-500-0005, or likely to be placed in one within the next thirty days in the absence of home or community-based LTC services provided under one of the programs listed in subsection (1) of this section;

(e) Have attained institutional status as described in WAC 388-513-1320;

(f) Be determined in need of home or community-based LTC services and be approved for a plan of care as described in subsection (2)(a)(i), (ii), or (iii);

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted:

(i) Enhanced adult residential care (EARC) facility;

(ii) Licensed adult family home (AFH); or

(iii) Assisted living (AL) facility.

(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1364, 388-513-1365 and 388-513-1366; and

(i) Meet the resource and income requirements described in subsections (3), (4), and (5) or be an SSI beneficiary not subject to a penalty period as described in subsection (2)(h).

(3) Refer to WAC 388-513-1315 for rules used to determine nonexcluded resources and income.

(4) Nonexcluded resources above the standard described in WAC 388-513-1350(1):

(a) Are allowed during the month of an application or eligibility review, when the combined total of excess resources and nonexcluded income does not exceed the special income level (SIL).

(b) Are reduced by medical expenses incurred by the client (for definition, see WAC 388-519-0110(10)) that are not subject to third-party payment and for which the client is liable, including:

(i) Health insurance and Medicare premiums, deductions, and co-insurance charges; and

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan.

(c) Not allocated to participation must be at or below the resource standard. If excess resources are not allocated to participation, then the client is ineligible.

(5) Nonexcluded income must be at or below the SIL and is allocated in the following order:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Maintenance and personal needs allowances as described in subsection (7), (8), and (9) of this section;

(c) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(d) Income garnisheed for child support or withheld according to a child support order:

(i) For the time period covered by the maintenance amount; and

(ii) Not deducted under another provision in the post-eligibility process.

(e) Monthly maintenance needs allowance for the community spouse not to exceed that in WAC 388-513-1380 (6)(b) unless a greater amount is allocated as described in subsection (6) of this section. This amount:

(i) Is allowed only to the extent that the client's income is made available to the community spouse; and

(ii) Consists of a combined total of both:

(A) An amount added to the community spouse's gross income to provide the amount described in WAC 388-513-1380 (6)(b)(i)(A); and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for the community spouse's principal residence. These expenses are:

(I) Rent;

(II) Mortgage;

(III) Taxes and insurance;

(IV) Any maintenance care for a condominium or cooperative; and

(V) The food assistance standard utility allowance (for LTC services this is set at the standard utility allowance (SUA) for a four-person household), provided the utilities are not included in the maintenance charges for a condominium or cooperative;

(VI) LESS the standard shelter allocation listed in WAC 388-513-1380 (7)(a).

(f) A monthly maintenance needs amount for each minor or

dependent child, dependent parent or dependent sibling of the community or institutionalized spouse based on the living arrangement of the dependent. If the dependent:

(i) Resides with the community spouse, the amount is equal to one-third of the community spouse income allocation as described in WAC 388-513-1380 (6)(b)(i)(A) that exceeds the dependent family member's income;

(ii) Does not reside with the community spouse, the amount is equal to the MNIL for the number of dependent family members in the home less the income of the dependent family members. Child support received from an absent parent is the child's income;

(g) Incurred medical expenses described in subsection (4)(b) not used to reduce excess resources, with the following exceptions:

(i) Private health insurance premiums for PACE, MMIP, or WMIP((~~,~~
~~(ii) Medicare advantage plan premiums for PACE~~)).

(6) The amount allocated to the community spouse may be greater than the amount in subsection (5)(e) only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(7) A client who receives SSI does not use income to participate in the cost of personal care, but does use SSI income to participate in paying costs of board and room. When such a client lives:

(a) At home, the SSI client does not participate in the cost of personal care;

(b) In an enhanced adult residential center (EARC), adult family home (AFH), or assisted living (AL), the SSI client:

(i) Retains a personal needs allowance (PNA) of fifty-eight dollars and eighty-four cents;

(ii) Pays the facility for the cost of board and room. Board and room is the SSI federal benefit rate (FBR) minus fifty-eight dollars and eighty-four cents; and

(iii) Does not participate in the cost of personal care if any income remains.

(8) An SSI-related client living:

(a) At home, retains a maintenance needs amount equal to the following:

(i) Up to one hundred percent of the one-person FPL, if the client is:

(A) Single; or

(B) Married, and is:

(I) Not living with the community spouse; or

(II) Whose spouse is receiving long-term care (LTC) services outside of the home.

(ii) Up to one hundred percent of the one-person FPL for each client, if both spouses are receiving COPES, New Freedom, PACE, ((~~or~~)) MMIP, or WMIP services;

(iii) Up to the one-person medically needy income level (MNIL) for a married client who is living with a community spouse who is not receiving COPES, New Freedom, PACE, ((~~or~~)) MMIP, or WMIP.

(b) In an EARC, AFH, or AL, retains a maintenance needs amount equal to the SSI FBR and:

(i) Retains a personal needs allowance (PNA) of fifty-eight dollars and eighty-four cents from the maintenance needs; and

(ii) Pays the remainder of the maintenance needs to the facility for the cost of board and room. (Refer to subsection (11) in this section for allocation of the balance of income remaining over maintenance needs.)

(9) A client who is eligible for the general assistance expedited Medicaid disability (GAX) program does not participate in the cost of personal care. When such a client lives:

(a) At home, the client retains the cash grant amount authorized under the general assistance program;

(b) In an AFH, the client retains a PNA of thirty-eight dollars and eighty-four cents, and pays remaining income and GAX grant to the facility for the cost of board and room; or

(c) In an EARC or AL, the client only receives a PNA of thirty-eight dollars and eighty-four cents and retains it.

(10) The total of the following amounts cannot exceed the SIL:

(a) Maintenance and personal needs allowances as described in subsections (7), (8), and (9);

(b) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (5)(a); and

(c) Guardianship fees and administrative costs in subsection (5)(c).

(11) The client's remaining income after the allocations described in subsections (5) through (9) is the client's participation in the total cost of care.